

CHAPTER XII

OUTREACH IN URBAN AREAS

by G. Thomas Graf

Although authorities do not agree about the exact percentage of retarded persons among us, few would dispute that the problem of mental retardation is more severe in poor populations than in the middle and upper socio-economic levels of our society. The retarded citizen who is poor often lacks the rights and services available to more affluent handicapped persons simply because the poor are unaware of the services available and how to obtain these services. The mentally retarded person in urban poverty requires the same generic services as other retarded persons. While many retarded persons have been deprived of these services, those living in urban poverty have been even more deprived than others.

To meet the needs of mentally retarded citizens in our inner cities, we must understand not only their specific problems but also the political dynamics of change in the American system. The American political system responds to well organized and sophisticated pressure campaigns and influential citizens rather than to the worthiness of a particular cause. The complications and intricacies of the political process seem strange to most people, and especially so to the poor. For centuries mentally retarded people of all socioeconomic levels suffered both the inequalities and dehumanization of our system; only when middle-class parents organized the Association for Retarded Children and pressed for their children's rights did the American system respond. To deny the importance of middle-class involvement in the change process would be unrealistic and certainly misleading to an understanding of the avenues to social change in America.

The parent movement (ARC) historically has been composed of middle and upper-class parents fighting for services and more recently for the rights of their retarded children and adults. In the mid-sixties the national movement began to shift its emphasis from providing services primarily to the children of its membership to obtaining services for *all* retarded citizens. This shift of national association policy has resulted in many

states' passing laws mandating various community programs and services for all retarded persons. Many states now have mandatory education acts for exceptional children; others have passed community services acts providing for training centers, vocational centers, group homes, and diagnostic and evaluation services. Concurrently, the national parent movement began to deal more concretely with the particular problems posed by the relationship of poverty to mental retardation. To obtain basic rights for retarded persons, associations have begun to use the courts instead of legislative mandate. Because of this reliance on judicial decisions, middle-class parents could not seek a legal guarantee of the rights of their own alone without also seeking the guarantee for all retarded persons—black, white, rich, or poor.

THE SPECIAL PROBLEMS OF POOR FAMILIES WITH MENTALLY RETARDED MEMBERS

Beyond the political and legal issues, the complexities of urban living and service delivery pose major hurdles for all families, especially the poor. Metropolitan areas with their intricate governmental bodies, service agencies, school districts, boundaries, and overlapping services form an often incomprehensible and impenetrable maze. Simplification of a service-delivery system is seldom a reality in the United States. Consequently, urban living and service delivery problems require knowledgeable advocates for all retarded citizens, especially the poor.

Project STAR was such an advocate. STAR—a recent poverty project conducted by the National Urban League, Family Service Association of America, and the National Association for Retarded Children—concluded that, "There is an overall need to increase the capacity, effectiveness, and efficiency of services to the mentally retarded and their families, but particularly among the poor and minority families. Major problems in the service system that have contributed to this need are:

- gaps in service
- uneven distribution of services throughout the community
- varying quality of services, some excellent and some just meeting minimal standards
- fragmentation of services. Problems encountered here include:

- difficulties for the client in finding the best way to enter the service system —conflicting and inconsistent eligibility standards, especially for the multiply handicapped —
- inadequate mechanisms for comprehensive work-ups and case planning
- inadequate mechanisms for case management continuity for interagency services
- cumbersome mechanisms for assigning costs to the appropriate agencies —insufficient opportunities for staff development and infusion of new service techniques —
- insufficient planning and coordination among agencies with complementary services —insular attitudes tied to one type of client, disability, or service within agencies (public and private)
- inadequate input from low socioeconomic and minority groups." ¹

A lack of planning and program coordination of the broader service system presents major obstacles to all persons, but especially to the poor. During the past twenty years community services for mentally retarded children have grown rapidly throughout many sections of the United States. As a result of centuries of neglect, programs were too often initiated by a variety of public and private agencies without regard for enough short and long range planning or interagency coordination. In essence, we find an often sporadic array of services in our cities. Although national priority is beginning to shift towards the provision of well-integrated service models, a well-planned and coordinated service delivery system is too often the exception rather than the rule.

The Example of Adult Services. Many community-based service agencies are experiencing the consequences of planning neglect. Specifically, vocational rehabilitation agencies—by virtue of their concern and federal funding for adult services—are just now beginning to feel the impact of effective advocacy and ineffective interagency planning for the mentally retarded adult. Massive program development by one community service agency will sooner or later make an impact on others. Advocacy and public agencies initially demanded services for retarded

¹ Long, Earl L., "A Final Report on Project Star" (Serving to Advance Rehabilitation). National Urban League, Research and Demonstration Grant Number 15-p-55061/2-03 from Social and Rehabilitation Service, Department of Health, Education and Welfare, Washington, D.C., 1973, pp. 16-17.

children, specifically day care and special education. While some enacted mandatory education laws for exceptional children, others received a mandate from the courts that public education is a right of all citizens including mentally retarded ones. The court decisions and legislation mandating education for mentally retarded persons have resulted in identifying and then providing services for thousands of retarded children. We are experiencing a revolution in the development of community-based services for the retarded persons. Because this massive reform in education and other child-oriented services (day care, diagnostic and evaluation, and other treatment services) has caught the traditional adult-oriented service agencies ill prepared, vocational rehabilitation agencies are hearing thousands of special education and day care graduates knocking at their doors for service. This problem will continue to be acute for the inner city adult retarded citizen.

If employment and economic progress are major escape routes out of poverty, mentally retarded citizens living in America's inner cities must follow these routes. Why guarantee a person fifteen years of education (3—18) only to deny him the vocational training required to "succeed" in society? Although we must still emphasize creating and opening up employment opportunities for retarded citizens, we should give major priority to developing innovative pre-vocational and vocational training programs. Services for mentally retarded adults have changed little over the past two decades. For the most part we are still witnessing the limited, under-financed, sheltered workshop model of the early fifties.

Traditionally, vocational rehabilitation agencies have maintained a "case closure" mentality. They have given priority to those handicapped people with the potential for fast rehabilitation and case closure. Needless to say, this excluded most mentally retarded people.

Although employment opportunities for retarded persons generally exceed the ability of service agencies to fill them, the need for adult rehabilitation services exceeds the ability of traditional agencies to supply them. While more affluent parents may be able to make their own private short or long term provisions for their mentally retarded adults, this crisis in public provision victimizes the poor. The unemployed adult retarded person in the inner city is at great statistical risk of getting into trouble with the law and entering the criminal justice system. Vocational rehabilitation intervention by the community could save it from more costly and needlessly restrictive offender rehabilitation later on.

In view of these factors, a high national priority must *now* be given to expansion and integration of comprehensive adult services for retarded citizens—especially for those living in inner city poverty pockets.

Unless we follow up with adequate comprehensive adult services, we are wasting all the diagnostic and evaluation clinics, special education classes, day care centers, recreation programs, counseling, and group homes. We should give special priority to vocational training and job placement services for inner city retarded adults.

SPECIFIC OUTREACH STRATEGIES

Even if an ideal coordinated service system for retarded citizens existed in every American community, the poor would still face a very real dilemma. Despite the many available services to retarded persons, low income families know little about these valuable resources and programs. This fact alone produces the need for advocacy outreach services to assist families in obtaining these needed services. Although outreach programs are not the only special need of mentally retarded citizens living in poverty, they are one of the major needs of this group.

The scarcity of literature on advocacy and outreach models reveals the low priority our society places on persons who are both mentally retarded and poor. Aside from several pilot projects administered by the National Association for Retarded Children and a few state and local parent associations, little effort has been expended to reach out to poor families. With the start of Project RESCUE in 1969, the Atlanta Association for Retarded Children was one of the first to demonstrate a concern for mentally retarded members of poor families. Since, as Executive Director of this association, I was involved in developing the outreach project, I will draw heavily on this experience and Project STAR, mentioned above.

Pilot projects RESCUE and STAR represent valuable building blocks for new service models which can be adopted on a broader base throughout the United States.

Administrative Auspices. In developing an outreach program on the local or state level, one must consider two important factors: (a) Which agency can best administer the project? and (b) What are the possible sources of financial support?

A private, independent advocacy organization would be the best sponsor for an outreach program. It would have freedom to act and a pool of strong volunteers.

The sources of financial support should probably be diversified among private and public resources. High costs usually prohibit strictly private support, even though partial support must come from this area. Public funds should be sought from those public agencies least likely to be adversely affected by the advocacy program. Federal or state grants from public agencies removed from direct program operations are the best sources of public funding.

Human Resources. Assuming the appropriate independent agency secures funding from an independent source, we can now consider the operation of a quality service. Experience has shown that a useful outreach program begins with good staff and volunteers, i.e. professional staff, paraprofessional staff, and well-trained volunteer advocates at various levels of professional development. The real success of Atlanta's Project RESCUE has been attributed to its use of indigenous workers as home visitors. According to Patricia S. Powell, Director of RESCUE, "While our paraprofessional home visitors have not had a long formal education in counseling techniques, the home visitors' ability to empathize (enriched by their own similar backgrounds) and to convey their sincere concern and willingness to help has brought about the effective type of counseling needed by families who in the past have been unable to relate to 'ivory tower' therapists."

A model outreach-advocacy staff should also include a social worker, a nurse, and an administrator responsible for supervising and coordinating the program. The professionals train and back up the paraprofessional neighborhood workers or home visitors and also the volunteer advocates. Aside from the standard clerical and office workers, the staff also includes a part-time person skilled in public information techniques. He assists in preparing various types of community education materials and plays a key role in campaigns to recruit volunteer advocates from inner city agencies and neighborhoods.

The second major factor in RESCUE'S success was the initial intensive in-service training program for paraprofessional staff. The program included three major phases:

- (1) Lectures and discussions concerning mental retardation as a phenomenon: its varieties, causes, degrees, and potential treatments, including special emphasis on behavioral shaping techniques.
- (2) Field trips to and discussion of agencies and resources in metropolitan Atlanta which were already providing services to mentally retarded persons. In some cases

the paraprofessional staff could observe and briefly work with mentally retarded persons. (3) Orientation to other staff members, role allocations within the project, and the importance of openness and cooperation among team members. Continuous staff training and development progressed throughout the year. Visiting agencies' representatives, lectures, and films are scheduled periodically, and the professional staff members (social worker, nurse) provide continuous education and training in their areas of expertise. The educational process must emphasize practical situations and real problems. As a result RESCUE has experienced a low paraprofessional turnover—one out of seven per year.

This program's success lies in abandoning the traditional selection (academic), training (theoretical), and management (professional over sub-professional) models. It stresses teamwork—working together to help mentally retarded citizens and their families.

Finally, the heart of a good program is the "soldier" in the front line. If the professional staff does an adequate job of selection, provides continuous staff training, and reinforces the paraprofessionals through career advancement, then it has won half the battle.

Program Components. An outreach model should include the following ten components: (1) case finding, (2) referral, (3) parent training, (4) supportive counseling, (5) interagency cooperation, (6) target area-community education, (7) supportive advocates, (8) backup group advocacy support, (9) consumer input, and (10) law enforcement involvement.

(1) *Case Finding.* During the developmental stage of Project RESCUE we found case finding to be our most pressing problem, requiring a high priority. Lee Copple, RESCUE'S Project Analyst, discussed these problems in RESCUE 1971 Annual Report:

"There is no reason to suppose that the projected target population does not exist, but its identification poses unexpected difficulties. As yet, our understanding of these difficulties must of necessity be somewhat tentative and speculative, but we are inclined to think that it is based on one or all of the following elements: as compared to the 'middle class' populations in which case finding for MR services is more often done, our target population is (a) less knowledgeable about the nature of mental retardation, (b) less aware of the difference between a mentally retarded child and their normal siblings or companions,

(c) less sensitive to community pressures resulting from deviant behavior in children, (d) more inclined to accept the status quo as unchangeable, (e) less alert to community resources for problem solving, (f) more inclined to accept superstitions or guilt explanations of deviancy, (g) more preoccupied with maintaining day-to-day existence, (h) less able intellectually and emotionally to accept help. For these and possibly many other reasons, we do not see anything comparable to the aggressive demand for services for the mentally retarded which has resulted in so much change in national attitudes toward, and provision of services for, the mentally retarded in the last twenty-five years. Rather, we see a picture of apathy, and possibly even secrecy, and this has hampered our case finding."

Clearly, the outreach project must literally *reach out* to the family through its indigenous workers. And when the project does reach out, it may encounter suspicion, rejection, and, in some cases, racial prejudices. Although case finding will never be easy, it should improve once the project becomes better established and known among referring agencies and the target neighborhood themselves.

From the beginning, the project's staff must work closely with potential sources of referrals, for example, Model Cities, OEO, county welfare, and similar agencies. Other potential sources of referral to an outreach agency include vocation rehabilitation, hospitals, public school special education directors, school principals, community recreation directors, churches, juvenile courts, housing authorities, institutions, and health departments. In addition to such agency contacts and liaisons, approaches must be made through neighborhood newspapers, billboards, television, neighborhood organizations, and of course, the residents themselves.

In 1972 RESCUE received a total of one hundred two new referrals from thirty different sources. Success in working with referrals depends on the project's staff going to the retarded person and not waiting for him to come to the office. Once the agency receives referrals, it must determine the problems, needs, and service priorities. The process begins with a professional assessment and family interviews and concludes with a staff conference which sets the priorities and draws up a plan of assistance.

² Copple, Lee B., "Project RESCUE 1971 Annual Report," Atlanta Association for Retarded Children, Research and Demonstration Grant Number 5 H30 MRO3125-02 from Social and Rehabilitation Service, Department of HEW, Washington, D.C., 1971, p. 30.

(2) *Referral*. As a second major component, this program must make referrals to appropriate agencies. An outreach-advocacy project intervenes on behalf of a mentally retarded person, his family, and his community; referral is a basic tool of intervention. The home visitor, if he or she is to succeed, must address the needs of the entire family. Intervention may take the course of getting the children to a medical or dental clinic or assisting the parents in finding day care for the children so that the mother can work, thus improving the economic status for the family. In many cases, a home visitor's early intervention with so-called normal siblings can prevent mental retardation from striking again. Assisting the family in good nutrition and health care practices or finding early childhood education experience for the other children can dramatically affect and positively benefit the entire family.

Primarily, both professional and paraprofessional staff should use their knowledge of community resources to help the family and the retarded member receive *all* needed services. Each year the project should review its experiences with all services available to retarded citizens. RESCUE'S major 1972 referrals to other agencies are listed below.

	122
Medical Services	65
Vocational Placement	30
Parent and Client Training	70
Parent Counseling	16
Miscellaneous	60

PROJECT RESCUE REFERRALS OF CLIENTS

<i>Referrals to</i>	<i>Number</i>
Day Care and Training	

Earl Long, in the 1973 Final Report of Project STAR states, "Of the known outcomes of STAR referrals, seventy-four percent resulted in a service being delivered to the client."³ Atlanta's Project RESCUE experienced a similar rate of success with referrals.

In interviews, parents receiving outreach services stated: "The home visitors helped me find services for my child that I didn't know existed"—"they cut red tape"—"I didn't know my young retarded adult could get free medical care from my own doctor from Medicaid"—"I didn't know about Aid to the Disabled"—"they helped me with transportation to the clinic."

³ Long, Earl, "A Final Report on Project Star," *op. cit.* inside cover.

Referral implies much more than just telling parents about a service. It often means actually transporting the parents to the agency, helping them with the forms and application procedures, as well as following up the referral. All added up, it means direct intervention.

(3) *Parent Training.* A third major program component and opportunity for intervention, a parent training program, can improve the family's knowledge and skills in coping with the retarded person's problems. Parents need to know about opportunities for their child and about his rights and needs. Home visitors replace abstract, traditional methods with concrete, experimental approaches to teaching. Demonstrating that financial, social, educational, and health services can be obtained has proven to be more effective than words. For example, with Project RESCUE'S home visitors, parents of older over-protected retarded individuals went on tours of vocational centers and workshops so that these parents could see first hand other retarded adults succeeding in the outside world.

Sexual needs and behavior are also problem areas for parents. The home visitor can help by teaching a young woman to use prescribed birth control pills correctly or training an adolescent male not to masturbate in public.

In addition to the usual programs in toilet training, feeding, and dressing, other types of successful outreach home training programs include personal hygiene, food preparation, meal planning, child care, budgeting, housekeeping, bus riding, pedestrian safety, and discipline. Assistance in these areas greatly helps to create a better environment for the retarded person and his family.

(4) *Supportive Counseling.* For effective supportive counseling to poor families, home visitors must establish a trusting relationship from the beginning. In 1972 only three families out of one hundred two referrals rejected help from Project RESCUE'S home visitors. This success rate can be attributed to the selection of home visitors on the basis of factors other than formal education or experience. Also, an internal staff training program followed by continuous staff education and development activities aids the paraprofessional's successful supportive counseling; therefore, the professional staff must assist paraprofessionals when needed.

(5) *Inter agency Cooperation.* Only by developing a close and cooperative working relationship with the staff members and leaders from other agencies can an outreach program meet its broad-based objectives. In 1971 RESCUE listed twenty-three agencies frequently attending case staffings of common "clients."

These agencies included schools, workshops, legal aid, juvenile court, hospitals, institutions, health centers, crippled children services, and housing authorities.

The involvement of various interested agencies in planning for the client reduces duplication of services while exposing the client to the greatest number of possible services. A measure of Project RESCUE'S success in interagency cooperation and joint understanding can be found in its low four percent rejection rate for services in 1972. Of two hundred seventy-seven client referrals made in 1972, only eleven were rejected.

(6) *Target Area—Community Education.* The need for changing attitudes and eliminating myths about the mentally retarded person and his needs is just as important in the inner city as in other parts of the community. A good outreach project should include a comprehensive education and public information program aimed at improving the community's understanding of the problem. The program should use news letters, newspapers, speakers bureaus, radio and television, and all other communication media. Educational campaigns on the effect of lead paint poisoning, rubella, and prenatal care should be parts of the overall public information emphasis. This component of the project can inform the public about the needs of the retarded poor. In addition to these functions, the community education component can help recruit volunteer advocates.

(7) *Supportive Volunteer Advocacy.* The staff of an outreach program is limited in the amount and kind of services it can realistically provide to retarded persons and their families. Although the staff can provide a variety of individual advocacy services, many of their clients' needs must necessarily wait because of staff and program limitations. But a corps of trained volunteer advocates can supplement staff services to retarded persons and their families. Advocates can assist in a variety of areas such as transporting a family to visit their child in an institution, a medical facility, or school; providing homemaker services; picking up surplus food for the family; securing legal aid; or attending a ball game or picnic with retarded youngsters. The possibilities for volunteer advocacy are endless.

The professional project staff should recruit, select, train, and place volunteer advocates. Like the home visitors, volunteer advocates should be selected on the basis of warmth, sensitivity, and concern.

(8) *Backup Group Advocacy Support.* As mentioned, a large social action agency, perhaps a parents' organization,

should administer the outreach project. An individual advocate might find a public agency rejecting a retarded citizen if it were not for the possibility of reciprocal action from the parent organization. In numbers there is truly strength. The community prestige and strength of an association for retarded children provide the individual home visitor with supportive power to meet his client's needs. If the outreach project operates independently or as part of a public agency, it will lack the backup "clout" to meet its advocacy objectives. Under a social action agency with a large membership, the outreach project can channel information into that agency's priorities for legislation, program development, and objectives for social change.

(9) *Consumer Input.* Project RESCUE'S parent advisory board aided greatly with information, recommendations, and planning for activities. Members of the poverty population should be encouraged to participate in committees and other activities of the parent organization. They should have a voice in projects that will contribute to improving their own and their children's lives. Outreach consumers can be very effective in a campaign to eliminate lead paint poisoning in their Model Cities community.

In Atlanta, the consumer-based advisory board has undertaken several major projects. It directed a social action campaign at obtaining federal revenue-sharing funds from the city council to replace the categorical grant funding of RESCUE for the first five years. The parents met with individual aldermen to explain the importance of RESCUE services to them and other inner city parents of retarded children. Other direct projects included collection and disbursement of Christmas presents for needy retarded children and their families in the inner city. We have found many articulate and willing consumers who can and want to help shape and improve not only the lives of their own children but also the lives of others.

From a direct service standpoint, the inner city consumer can help vitally in case-finding for the outreach agency. The program's staff must heed consumers if progress is to be made in behalf of the inner city retarded citizen. But we must have more than "paper" advisory committees established to pacify bureaucratic requirements. The consumer must be involved in situations that really count.

(10) *Law Enforcement Involvement.* Within the poverty-stricken inner city a number of mentally retarded persons may be involved in some situation which will require the attention of a police officer. A police officer in the inner city not only acts as a deterrent to crime, but also provides service to the

mentally retarded. To better understand how a police officer can fit within an advocacy outreach model, we will examine these two functions in detail.

The role of the police as a deterrent to crime can cause a problem for the mentally retarded individual if he is suspected of committing a crime. Research has shown that the preferred targets of special police concern are some ethnic and racial minorities, the poor living in urban slums, and young people in general.⁴ Thus, a retarded individual may come under suspicion often if he is young, a member of a minority group, or from a low income area. Given this circumstance, one can understand why the policeman can be viewed as a threat by retarded persons and their families. What occurs in the court room can reinforce this feeling. Again, research shows that a young poor person from a minority race will receive a more severe sentence after conviction of a crime than a Caucasian convicted of the same crime.⁵

These circumstances cannot be easily corrected. An advocate/outreach group, however, can take certain steps. First, such a group must meet with the appropriate governmental body which sets police standards for training. This body should be persuaded to introduce a course on mental retardation as part of the regular training program. The proposed curriculum change should clarify the distinction between mental retardation and mental illness. The police trainee or officer needs an adequate understanding of some of the causes of mental retardation. In particular he should know about the relationship between poverty and mental retardation. Most current police training materials fail to do this adequately. When the standards' committee agrees to change the curriculum and increase the number of hours of instruction in mental retardation, those proposing the change should help develop the new materials. In some instances, local Associations for Retarded Children have been invited to instruct police either in the academy or in special workshops or in-service training sessions.

Also, police and trainees must have personal contact with mentally retarded individuals. The trainees need to understand that mentally retarded people often do not look any different, nor would their behavior usually identify them as different. Trainees might visit workshops, training centers, or group homes where they would see the retarded people functioning in

⁴ Bittner, Egon. "The Functions of the Police in Modern Society" National Institute of Mental Health, 1973, p. 10.

⁵ Thornberry, Terence, "Race, Socioeconomic Status and Sentencing in the Juvenile Justice System," The Journal of Criminal Law and Criminology 16, 1973,

a normalized setting. A visit to a hospital for retarded persons would be quite inappropriate since it would not represent them in a community setting. A visit to a local group home would particularly help. The trainee could see that he really will encounter mentally retarded people in his patrol of a neighborhood.

To better the relationship between the community and the police, an advocate group might work closely with the community relations division of the police department. This division provides police officers as speakers to groups of interested and concerned people. The advocate group could suggest that members of the division visit classes, centers, and group homes to discuss law enforcement with retarded citizens themselves. In other words, not only must the police understand mentally retarded people, but mentally retarded persons must learn to understand and appreciate the police.

As another way to help, an advocate group can inform the police about resources to which they can turn when they encounter someone they suspect is retarded. Advocate groups can provide this valuable information as well as the telephone numbers of individuals who will volunteer to be on call in case no professional retardation workers are available.

The next step a concerned group might take involves advocacy in the purest form, individual advocacy. Parents, friends, and relatives are not the only advocates for retarded citizens; policemen can also serve as individual advocates. In many metropolitan areas the Police Athletic League (PAL) shows police interest in personal service. Advocate groups working with the police community relations division or a similar section can develop a program which would give the policeman the opportunity to become the advocate for a retarded individual.

With the emergence of the circumstances described above, the second and equally important role of the police officer as protector can be more fully realized. An officer trained in recognizing and handling mentally retarded persons will be more comfortable in this role when he encounters a situation involving a mentally retarded person. Because only about ten percent of police calls strictly concern law enforcement and the other ninety percent fall into the categories of information gathering, service and order maintenance, the police officer certainly has ample opportunities to respond to people in a non-authoritarian manner.⁷ If an advocacy/outreach group establishes a good relationship between the police and the com-

⁷ Cull, John, Richard Hardy, *Criminal Rehabilitation Within and Without the Walls*, Charles Thomas, 1973, p. 179.

munity, the police can function more often as service providers, especially if the advocacy group can establish a mechanism for emergency admittance to a service such as a special group home. This would be a very useful service not only for the police but also for the retarded individual who has to be removed from a potentially dangerous situation. Many states have a uniform alcoholism act which states that an alcoholic cannot be locked up for being intoxicated, but must be treated. An act similar to this would aid a policeman who feels that the best procedure would be the removal of a retarded individual from a potentially dangerous situation. Overnight housing in a community facility—an emergency care unit—would be far better than detention in a jail cell.

Although law enforcement is only the first step in the criminal justice process, an advocacy/outreach program can have its greatest impact at this primary entrance to that process. The provisions of alternatives for police handling are preferable to correctional alternatives. A retarded citizen usually need not enter the criminal justice process. In summary, an advocacy group should develop an educational program and offer alternatives to incarceration so that an informed policeman knows where to turn for assistance.

A NATIONAL CALL TO ACTION

We have examined just a few of the problems relating to mental retardation and poverty. We have also seen some specific outreach and advocacy components designed to assist poor families confronted with the problem of mental retardation. As important and helpful as these approaches might be, they still address themselves only to a small element of a much broader concern—eliminating mental retardation caused by poverty and developing comprehensive supportive services for those poor persons already affected by the problem. As mentioned earlier, only a few outreach models are now operating in the United States, and most of those are funded on a short-term demonstration basis.

As a nation, we must attack the total problem of mental retardation and poverty. To make real progress, various advocate agencies for mentally retarded persons and the poor in general must begin to pool their resources and coordinate their efforts.

We know the basic conditions of poverty: segregation,

prejudice, racism, poor education, inadequate health care, second-rate housing, inadequate and archaic welfare programs, and an American value system which places a higher priority on technology and objects than on people. As a result of this priority system, a man can walk on the moon and proclaim "one step forward for mankind" while back on earth a child cries out from hunger. In America a retarded child may be denied special education because not enough money is in the school system's budget, and another child denied health care because his family lacks the necessary means to get this help. One step forward for mankind?

Government responds to the "will of the people" as expressed by lobbying power. In the field of health, education, and welfare we have fragmented our efforts. Associations for Retarded Children lobby, Mental Health Associations lobby, National Education Associations lobby, Civil Rights groups lobby; every group does its piece. The returns have been equally fragmented. Yet, the interrelationships of needs are quite apparent. Better schools in ghettos help prevent the perpetuating cycle of poverty and, thus, help reduce mental retardation due to poverty. Yet, the elected officials hear fragmented voices. Because of fragmented efforts in health, education, and welfare, more money goes for space and defense. The implications are clear. The procedure for accomplishing our objectives should be equally clear. We in retardation must begin to work more closely with other social action agencies and coordinate our lobbying and legislative efforts. A federation of individuals and organizations with common and interrelated interests, formed for mutual interests and self-defense without forfeiture of individuality or self-determination, is needed in health, education, and welfare just as it was in the American labor movement. A catalyst must fuse these organizations for their own self-protection. This is also the American way. Through it, we might influence the American priorities in a more humane direction.

If we are to solve the problem of mental retardation and poverty, we need better general education, housing, health care, vocational training, employment opportunities for all citizens. The need for specific outreach and supportive programs for the poor will require federal spending. No one advocate agency can accomplish the mission, but the unified effort of many can begin to bring about positive change.

Our national, state, and local associations for retarded children must reevaluate their own image, their own value system, their own commitment to serving all retarded persons;

black or white, rich or poor. Do we mean what we say? Are we willing to change? Are we willing to get involved? Are parents of retarded children as willing to write letters to congressmen for better health care and education for the poor as they are for specific services for their own child?

Ideally and intellectually we can see the advantages of a lobbying coalition. We have seen it work for other movements and concerns. The real question is not whether it can be done, but rather, are the concerned agencies willing to do it?

SUMMARY

Services for retarded citizens have proliferated during the last decade. Despite this growth a segment of the population remains inadequately served. These citizens reside in America's inner cities; they are the poor who are retarded or who have a retarded family member. This chapter has examined the documented relationship between poverty and mental retardation and the current critical need for adequately planned adult services in inner cities. It has described the necessary basic components for developing an effective outreach service designed to bridge the gap between services and the needs of mentally retarded persons living in poverty. Only a unified commitment of health, education, and welfare advocate agencies will brighten the future of these persons.